STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155772	A. BUILDING 01 B. WING	03/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COBBLESTONE CROSSINGS HEALTH CAMPUS	1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 03/14/12 Facility Number: 011906 Provider Number: 155772 AIM Number: 200912380 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Cobblestone Crossings Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This fully sprinklered facility was located on the north side of a one	K0000	The submission of this plan of correction does not indicate an admission by the Cobblestone Crossings Health Campus that the findings and allegations contained herein are an accurate and true representation of the quality of care and services provided to the residents of Cobblestone Crossings Health Campus. This facility recognized its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18 program). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	story building determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms. The facility has a capacity of 60 and had a census of 45 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/16/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

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K0048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to provide a written plan which included the transmission of the fire alarm and use of the K class extinguisher in the written fire plan for the protection of 52 of 52 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on review of the Fire Safety	K0048	No residents suffered ill effects from the alleged deficiency.Completion Date 4-10-12All residents have the potential to be affected by the deficient practice and through alteration in processes and in servicing the campus ensures there is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Completion Date 4-10-12All staff inserviced on the policy and procedures for fire safety. Systemic change is the policy regarding fire safety was revised.Completion Date 4-10-12Plant Operations Supervisor/desigee will complete random staff questionaires on fire safety to ensure understanding of policy. Will complete 1 employee questionaire per day for 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completion Date 4-10-12	04/10/2012

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	and Disaster Preparedness Manual provided as evidence of policy and procedures for fire safety with the maintenance supervisor and regional plant operations director on 03/14/12 at 11:55 a.m., a page titled Fighting the Fire from Operational Procedures (A-4) instructed staff to "immediately begin fire fighting procedures" when a fire was discovered and directed use of ABC fire extinguishers. "Our office uses only ABC extinguishers which will work on all types of fires except magnesium." No mention of the K class extinguisher in conjunction with the kitchen fire extinguishing system was included. Page A-2 titled Discovering a Minor Fire instructed staff to extinguish a minor fire and "Do not evacuate unless it is necessary." There was no instruction to activate an alarm. The regional plant operations director acknowledged at the time of record review, the plan did not have all required elements. 3.1-19(b)			

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K0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4 Based on observation and interview, the facility failed to ensure 2 of 5 cylinders of nonflammable gases in the oxygen storage room were properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 14 residents on the 100 hall. Findings include: Based on observation with the maintenance supervisor and plant	K0076	No residents suffered ill effects from the alleged deficiency.Completion Date 4-10-12All residents have the potential to be affected by the deficient practice and through alteration in processes and inservicing the campus will ensure medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.Completion Date 4-10-12All staff inserviced on storage ofoxygen e-cylinders and portable liquid oxygen tanks. Systemic change was added securing device for e-cylinders.Completion Date 4-10-12Director of Plant Operations/designee will audit oxygen storage room to ensure proper medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. Will monitor 5x a week for a month then 3x a week for a month then weekly with	04/10/2012

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	operations director on 03/14/12 at 12:45 p.m., two oxygen e-cylinders were stored without support in the oxygen supply storage room with six liquid oxygen containers. The maintenance supervisor acknowledged at the time of observation, the cylinders should have been support. 3.1-19(b)		results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments.Completio n Date 4-10-12	

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K0143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure the transfer of oxygen took place in an area separated from areas where residents were housed for 1 of 1 oxygen transfer sites. This deficient practice could affect visitors, staff and 14 residents on the 100 hall. Findings include: Based on observation with the maintenance supervisor and regional plant operations director on 03/14/12 at 12:45 p.m., the liquid oxygen transfer and storage room was identified by the maintenance director. The room	K0143	No residents suffered ill effects from the alleged deficiency.Completion Date 4-10-12All residents have the potential to be affected by teh deficient practice and through alterations in processes and in servicing the campus will ensure the transferring of oxygen takes place in an area separated from areas where residents were housed for 1 of 1 oxygen transfer sites. Completion Date 4-10-12All staff inserviced on transferring of oxygen. Systemic change is that hooks were added for storage of portable cylinders, removal of helium tank, and rearrangement of room to allow more space. Completion Date 4-10-12Director of Plant Operations/designee will audit oxygen transferring to ensure it takes place in an area seperated	04/10/2012

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	was filled to capacity with four liquid oxygen tanks, five oxygen cylinders, portable units and a large helium gas tank leaving approximately eight inches between the tanks and entry door. The maintenance supervisor said at the time of observation, a "skinny person" could actually enter and close the door behind them to fill a portable oxygen tank from a liquid oxygen supply tank. The regional plant operations director acknowledged at the time of observation, it was unlikely the door would be closed during transfilling due to to lack of space. 3.1-19(b)		from areas where residents are housed. Audits will be completed 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments.Completio n Date 4-10-12	